

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis Children's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 hours**
(Specify whether
In this community **15 hours - 15 min.**
years, months or days)

3. (a) PRINT
FULL NAME

Baby Girl Harsha

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex **F**

5. Color or
race **W**

6. (a) Single, widowed, married,
divorced **S**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive years

7. Birth date of deceased

August 19 1941
(Month) (Day) (Year)

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

15 hr. 15 min.

9. Birthplace

St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name **Theodore Henry Harsha**

13. Birthplace **Vergennes, Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Ruth Margaret Fleming**

15. Birthplace **Vergennes, Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant

Father T. H. Harsha

(b) Address

Vergennes, Illinois

17. (a)

(b) Date thereof

8-28-41
(Month) (Day) (Year)

(c) Place: burial or cremation

CITY CEMETERY

18. (a) Signature of funeral director

Isa Hamilton

(b) Address

City Health Dept

19. **AUG 27 1941**

(b)

J. H. H. H.
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **985**
(c) City or town **Vergennes**
(If outside city or town limits, write "RURAL")
(d) Street No. **720**
(If rural, give location)
(e) Citizen of foreign country? **(Yes or No)**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **19**
year **41** hour **5** minute **30 p. M.**

21. I hereby certify that I attended the deceased from **8-19**
19 **41** to **8-19** 19 **41**
that I last saw **he** alive on **8-19** 19 **41**
and that death occurred on the date and hour stated above.

Immediate cause of death

prematurity

Duration

14 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

(M. D. or other)

Address

Date signed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.